STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345247	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Nursing and Rehabilitation Center	**581 NC Highway 16 South , Taylorsville, North Carolina, 28681**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted from 01/04/26 through 01/08/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1DFCA5-H1.	E0000		01/22/2026
F0000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted from 01/04/26 through 01/08/26. The following intakes were investigated: 2699638, 2699088, 2682190, 2663192, 2658965, 2632518, 2619042, 2609755, 2595947, 2583045, 852376, 852373, 852371, 852370 and 852368. Five (5) of the thirty-seven (37) complaint allegations resulted in deficiencies, See Event ID #1DFCA5-H1.	F0000		01/22/2026
F0641 SS = A	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification.	F0641		01/22/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0641 SS = A	Continued from page 1 §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff and resident interviews, the facility failed to accurately code an admission Minimum Data Set (MDS) assessment in the area of medications for 1 of 6 residents reviewed for unnecessary medications (Resident #21). The findings included: Resident #21 was admitted to the facility on 11/24/25. The active physician orders for Resident #21 from 11/24/25 through 12/01/25 revealed no orders for insulin. Review of Resident #21's Medication Administration Record (MAR) from November 2025 revealed no documentation that he received an insulin injection. Review of Resident #21's MAR from December 2025 revealed no documentation that he received an insulin injection. A modified admission MDS assessment dated 12/01/25 indicated Resident #21 was cognitively intact and coded as having received insulin one (1) day during the lookback period. The assessment was completed by MDS Nurse #3. An interview with Resident #21 on 01/04/26 at 3:02 PM revealed he had not taken any insulin since he had been admitted to the facility. Resident # 21 explained that he was not a diabetic and had not ever taken insulin. An interview with Regional MDS Nurse on 01/08/26 at 2:14 PM revealed that Resident #21's modified admission MDS assessment dated 12/01/25 was completed by MDS Nurse #3 who was no longer at the facility. After	F0641		

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F0641 SS = A	Continued from page 2 reviewing the MDS assessment, the Regional MDS nurse explained it looked like Resident #21 had a tuberculosis test administered which was an injection and that the MDS Nurse #3 simply miscoded that injection as an insulin injection. The Regional MDS Nurse reported based on Resident #21's medical record Resident #21 was not receiving insulin and had never received insulin during his admission to the facility. An interview with MDS Nurse #3 was attempted via telephone call on 01/08/26 but was unsuccessful. An interview with the Director of Nursing (DON) on 01/08/26 at 2:41 PM revealed she did not believe that Resident #21 received insulin and stated that any resident in the facility that was not receiving insulin injections should not be coded on the MDS assessment as receiving insulin. The DON explained that the MDS assessments should accurately reflect a resident's condition and the medications taken. An interview with the Administrator on 01/08/26 at 2:45 PM revealed she expected MDS assessments to accurately reflect a resident's conditions and medications.	F0641		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to follow professional standards of practice for the safe administration of medications for 1 of 1 resident reviewed for self-administration of medications (Resident #65). Resident #65, who had been assessed as unable to self-administer medications, had medications left at his bedside without nursing supervision. The findings included: Resident #65 was admitted to the facility on 12/22/25 with diagnoses that included respiratory failure and generalized muscle weakness.	F0658	•Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. F658 Services Provided Meet Professional Standards of Quality The Facility failed to follow professional standards of practice for the safe administration of medications for a resident reviewed for self-administration of medications who had been assessed as unable to self-administer. Step 1: Corrective Action: Immediately upon identification on 1/5/26 the Director of Nursing secured all medications left at the bedside and completed a medication self-administration assessment on Resident #65, noted that resident cannot self-administer. The provider visited resident #65 on 1/5/26 with no concerns or changes identified. The Assistant Director of Nursing educated the assigned licensed nurse on self-administration practices and storage of self-administered medications. Step 2: Identification of other residents: On 1/5/26 the Director of Nursing observed all resident	01/15/2026

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F0658 SS = D	Continued from page 3 Resident #65's Admission Minimum Data Set (MDS) assessment dated 12/29/25 revealed he was cognitively intact and had no behaviors or rejection of care. A Self-Medication Assessment dated 12/22/25 revealed Resident #65 was assessed as unable to self-administer medications. An observation on 1/05/26 at 8:42 AM revealed Resident #65 lying in his bed with his head raised. A medication cup, on his bedside table within reach, contained 3 round light green pills, 3 round white pills, 1 smaller round white pill, 2 oval white pills and 2 round dark orange pills. An additional medication cup containing an amber liquid was also observed on the bedside table. Resident #65 indicated he knew what all his pills were because he had been taking them for so long that he was able to recognize them. He revealed the nurse would leave his pills with him and return later to get the empty cups. Resident #65 indicated he could take his pills by himself and didn't need anyone watching him. He declined to name the medications in the cup. An interview on 1/05/26 at 10:28 AM with Nurse #3 revealed Resident #65 asked her to leave his medications with him as he wanted to take them by himself. She indicated it was his preference to have his medications left, and he would become angry if you stood over him to watch him take his medication. Nurse #3 revealed she didn't know if Resident #65 had been assessed as safe to self-administer his medications and stated she should not have left the medication on his bedside table and walked out of his room. On 1/07/26 at 9:41 AM an interview with the Director of Nursing (DON) revealed the admitting nurse should complete self-medication assessment and communicate the outcome to the nurses on the hall. She indicated Nurse #3 should not have left Resident #65's medications by his bedside to self-administer as he had been assessed as unable to self-administer. The DON revealed she was aware of the incident and had begun education to nurses on resident self-administration of medications. An interview conducted on 1/08/26 at 11:02 AM with the Administrator revealed that Resident #65 should not have had his medications left at the bedside for self-administration. The Administrator stated that Resident #65 required reassessment for self-administration of medications and that nursing staff would be re-educated on the facility's process for resident self-administration of medications.	F0658	Continued from page 3 rooms to ensure no medications were at the bedside, no additional medications were observed. Director of Nursing and Assistant Director of Nursing completed audit of medication self-administration assessments on all current residents on 1/14/2026 to ensure that the assessments were up to date and accurate. No additional findings identified. Step 3: Measures to prevent Recurrence: Education was provided for all licensed nursing staff and medication aides by the Director of Nursing on 1/9/26 regarding the Self Administration of Meds Policy to include residents physical and mental ability to self-administer, appropriate medications, assessment completion, documentation and storage of medications utilized for self-administration. Education will be provided to newly hired or contracted licensed nurses and medication aides by the Director of Nursing or Assistant Director of Nursing upon hire prior to receiving an assignment. Step 4 Monitoring and Maintain Compliance: The Director of Nursing or Designee will observe five medication administrations weekly for six weeks and then monthly for three months, to ensure medications are administered and stored according to residents assessed ability for medication self-administration. The Administrator and/or Director of Nursing will report findings of these audits to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months for tracking and trending purposes with all follow up action determined by the QAPI team. Date of Compliance: _1/15/26_____	
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More	F0759	•Preparation and submission of this POC is required by	01/15/2026

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F0759 SS = D	Continued from page 4 CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and staff and Nurse Practitioner interviews, the facility failed to have a medication error rate of less than 5% as evidenced by 2 medication errors out of 26 opportunities, resulting in a medication error rate of 7.69% for 1 of 4 residents observed during the medication administration (Resident #6). The findings included: Resident #6 was admitted to the facility on 08/28/24 with diagnoses that included hypertension. Review of Resident #6's physician orders revealed an order dated 11/07/25 for folic acid (a vitamin critical for making new cells to prevent anemia) 800 micrograms (mcg) by mouth once a day. There was an order dated 11/26/25 for carvedilol (used to treat high blood pressure) 6.25 milligrams (mg) by mouth twice a day for hypertension. Hold for systolic blood pressure below 100 and heart rate below 60. On 01/06/26 at 8:30 AM an observation of a medication pass was conducted with Nurse #1. The Nurse prepared medications for Resident #6 which included carvedilol 6.25 mg and administered the medication to the Resident without assessing the Resident's blood pressure and heart rate before giving Resident #6 the carvedilol. During the same medication observation, Nurse #1 did not administer the folic acid 800 mcg to Resident #6. At 9:30 AM on 01/06/26 an interview was conducted with Nurse #1 who explained that she did not notice the parameters for the blood pressure and heart rate that was attached to the carvedilol order and stated it must have been added since the last time she worked with Resident #6. The Nurse stated she must have overlooked the order for the folic acid. On 01/07/2026 at 10:07 AM an interview was conducted with the Nurse Practitioner (NP) who stated that she	F0759	Continued from page 4 state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. F0759 Free of Medication Error Rate 5% or More Valley Nursing and Rehab failed to have a med error rate of 5 percent or lower. Step 1: Corrective Action: Immediately upon identification, Resident #6 was assessed to include vital signs by the Licensed Nurse; no abnormal findings were noted. Provider was notified of medication errors on 1/6/2026 by Assistant Director of Nursing. The provider then reviewed medications, and the dose of folic acid was changed from 800mcg to 1mg with an administration start date of 1/7/2026. In addition, one to one education was provided to the administering licensed nurse on 1/6/26 by the Assistant Director of Nursing regarding obtaining vital signs to ensure they are within ordered parameters, as well as, contacting the provider when medications are not available. Step 2: Identification of other residents: The Director of Nursing reviewed the order listing report for all residents receiving folic acid on 1/6/2026 to ensure that the ordered dose was available in the facility, no additional findings noted. On 1/14/26, the Director of Nursing, Assistant Director of Nursing, and the Nursing Unit Managers obtained vital signs on all current residents to ensure that medications had been administered as ordered. All resident vital signs were noted to be within normal limits. Step 3: Measures to prevent Recurrence: Education was provided for all licensed nursing staff and medication aides by the Director of Nursing on 1/9/26 regarding the "Ten Rights" of medication administration, obtaining vitals as ordered, contacting provider if a medication is unavailable and notification to nursing management if an error has occurred. Education will be provided to newly hired or contracted licensed nurses and medication aides by the Director of Nursing or Assistant Director of Nursing upon hire prior to receiving an assignment. Step 4 Monitoring and Maintain Compliance: The Director of Nursing or Designee will observe five	

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F0759 SS = D	Continued from page 5 was already aware of the medication errors that Nurse #1 had made. She explained that there were parameters on the carvedilol for a reason because it could drop the blood pressure and heart rate and that it would be necessary for a base reading to be obtained before the medication was given. The NP stated Nurse #1 should have read the medication record closer to obtain the blood pressure and heart rate prior to administration of the medication. The NP stated that medications were ordered for a reason, and she expected the nurses to give the medications that were ordered. She stated Nurse #1 should have looked closer at the medication administration record to avoid making errors. An interview was conducted with the Director of Nursing (DON) on 01/07/2026 at 2:45 PM, who explained that she was aware of the medication errors made by Nurse #1 not administering the folic acid and not checking the blood pressure and heart rate for Resident #6. The DON stated that the provider who entered the order for the carvedilol did not set up the parameters for the blood pressure and heart rate correctly in the system because if they had, the system would not have allowed Nurse #1 to check it off as being given without the parameters being documented. The DON stated the Nurse should have checked each medication order three times to prevent the medication errors.	F0759	Continued from page 5 medication administrations weekly for six weeks, then five monthly for three months to ensure that medications are administered as ordered. The Administrator and/or Director of Nursing will report findings of these audits to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months for tracking and trending purposes with all follow up action determined by the QAPI team. Date of Compliance: _1/15/26_____	
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F0761	•Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. F0761 Label/Store Drugs and Biologicals The Facility failed to secure controlled substance medications under a double lock in one medication room. Step 1: Corrective Action: Immediately upon identification on 1/7/26, the Director of Nursing locked the affixed controlled substance box in the medication room refrigerator. Step 2: Identification of other residents: The Director of Nursing completed an audit of all controlled substance storage areas on 1/7/26 to include medication room refrigerators, medication carts and STAT safes. No additional storage concerns were identified. Step 3: Measures to prevent Recurrence:	01/15/2026

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F0761 SS = D	Continued from page 6 Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and staff interviews, the facility failed to secure controlled substance medications under a double lock in 1 of 3 medication rooms reviewed for medication storage (Main medication room). The findings included: On 01/07/26 at 11:15 AM the unlocked refrigerator in the Main medication room was checked for medication storage along with the Director of Nursing (DON). The observation yielded four bottles of liquid lorazepam (benzodiazepine) with 30 ml each and two bottles of liquid morphine (opioid pain reliever) with 30 ml each, which are controlled substances. The liquid lorazepam and the liquid morphine were in a box affixed to the inside of the refrigerator, but the box was unlocked. The DON explained that Nurse #2 had the key to the box and the box should be always locked. At 11:30 AM on 01/07/26 an interview was conducted with Nurse #2 who confirmed that she had the key to the controlled substance locked box in the refrigerator that contained the lorazepam and morphine. The Nurse explained that she counted the medications with the third shift nurse earlier that morning and she must have forgotten to lock the box back after the medications were counted. An interview was conducted with the Administrator on 01/09/26 at 2:55 PM. The Administrator indicated her expectation was that the controlled substances be locked up no matter if they were in the medication cart or refrigerator.	F0761	Continued from page 6 Education was provided for all licensed nursing staff and medication aides by the Director of Nursing on 1/9/26 regarding the facility's-controlled substance policy with emphasis on storage requirements, including double locking and access control. Education will be provided to newly hired or contracted licensed nurses and medication aides by the Director of Nursing or Assistant Director of Nursing upon hire prior to receiving an assignment. Step 4 Monitoring and Maintain Compliance: The Director of Nursing or Designee will conduct audits of all controlled substance storage areas five days a week for six weeks, then weekly for three months to ensure controlled substances are stored under double lock. The Administrator and/or Director of Nursing will report findings of these audits to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months for tracking and trending purposes with all follow up action determined by the QAPI team. Date of Compliance: __1/15/26_____	
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F0880	•Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. F880 Infection Control and Prevention The facility failed to follow their handwashing/ Hand Hygiene policy when the Wound Nurse did not doff her gloves, perform hand hygiene and don clean gloves before moving to a second wound on a resident.	01/15/2026

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F0880 SS = D	Continued from page 7 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F0880	Continued from page 7 Step 1: Corrective Action: The licensed Wound Care Nurse received one to one education on 1/9/26 provided by the Director of Nursing regarding the hand hygiene policy and Infection Control during wound care. On 1/9/26 the Director of nursing observed a treatment performed by the wound care nurse and validated competency. Resident #10 was assessed by provider on 1/6/26 with no wound concerns noted. Step 2: Identification of other residents: The Director of Nursing reviewed wound reports on 1/9/26 for the last 30 days on all residents receiving wound care treatments for any concerns of worsening. No concerns identified. Step 3: Measures to prevent Recurrence: Education was provided for all licensed nursing staff by the Director of Nursing on 1/9/26 regarding wound care policy and hand hygiene requirements to include proper glove use, including changing gloves between different wounds and applying new dressing. Education will be provided to newly hired or contracted licensed nurses by the Director of Nursing or Assistant Director of Nursing upon hire prior to receiving an assignment. Step 4 Monitoring and Maintain Compliance: The Director of Nursing or designee will conduct ten weekly wound care treatment observations for appropriate hand hygiene practices for six weeks, then ten monthly for three months. The Administrator and/or Director of Nursing will report findings of these audits to the Quality Assurance Performance Improvement (QAPI) Committee monthly for three months for tracking and trending purposes with all follow up action determined by the QAPI team. Date of Compliance: _1/15/2026_____	

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F0880 SS = D	Continued from page 8 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and staff interviews, the facility failed to follow their Handwashing/Hand Hygiene policy when the Wound Nurse did not doff (remove) her gloves, perform hand hygiene and don (put on) clean gloves before moving to a second wound on Resident #10. The deficient practice occurred for 1 of 4 staff members observed for infection control practices (Wound Nurse). The findings included: Review of the facility's policy and procedure entitled Hand Hygiene and dated October 2023 read in part: Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene:Immediately before touching a resident.Before performing an aseptic taskAfter contact with blood, body fluids, or contaminated surfaces.After touching a residentAfter touching the resident’s environmentBefore moving from working on a soiled body site to a clean body site on the same resident; andImmediately after glove removal. A wound treatment observation was made on 01/06/26 at 10:01 AM on Resident #10 with the Wound Nurse. The Wound Nurse donned a clean gown and clean gloves. She then removed the old dressing from Resident #10’s left hip, doffed her gloves, sanitized her hands, donned clean gloves and cleaned the wound to Resident #10’s left hip. While wearing the same gloves the Wound Nurse then applied collagen powder with silver alginate to the left hip wound. The Wound nurse then proceeded to move to the next wound located on Resident #10’s right	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345247	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Nursing and Rehabilitation Center	**581 NC Highway 16 South , Taylorsville, North Carolina, 28681**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = D	Continued from page 9 ankle without doffing her gloves and sanitizing her hands. The Wound Nurse applied skin prep (skin protectant film) to the right ankle. She then collected all of her supplies and threw them into the trash can. The Wound Nurse doffed her gown, gloves and washed her hands. An interview conducted on 01/06/26 at 10:21 AM with the Wound Nurse revealed she was aware that she had not sanitized her hands and changed her gloves between the dressing changes on Resident #10's left hip and right ankle. She stated there was a lot going on in the room which made her nervous and she had just moved to the next wound without thinking. The Wound Nurse stated she had received ongoing education on infection control and dressing changes, that it was just a mistake. An interview on 01/07/26 at 2:22 PM with the Director of Nursing (DON) and Infection Preventionist revealed they both were aware of the Wound Nurse's errors during wound care. The DON said the Wound Nurse had been provided with additional education regarding doffing and donning and sanitizing in between wound care. The DON and Infection Preventionist stated it was their expectation for the Wound Nurse to follow infection control best practices to avoid introducing microorganisms into the wounds. An interview on 01/07/26 at 11:28 AM with the Administrator revealed she would expect the Wound Nurse to follow the Hand Hygiene policy for wound care.	F0880		